Telemedicine Clinical Advisory Group (TCAG)
July 7, 2011
Meeting Notes

Attendees

Robert Bass-MIEMSS, TCAG, Chair, Barney Stern–U of Maryland, Eric Aldrich-JHHS/HCGH, Salliann Alborn-Community Health Integrated Partnerships, Anna Aycock-MIEMSS, Laura Pimentel-ACEP, Brian Grady-U of Maryland/Psych, Mimi Novello-Medstar Health, Rich Colgan-UMB, Frank Genova-Kaiser, Ivor Berkowitz-Johns Hopkins, Grace Zaczek-DHMH, Jennifer Fahey- U of Maryland SOM, Richard Alcorta-MIEMSS, Neal Reynolds-STC/MEDCHI, Tricia Handel, Maryland Board of Physicians, E. F. Magee-MIEMSS, Stephen Michaels-St. Mary's Hospital/Medstar, Pat Gainer-MIEMSS, Elizabeth Vaidya-State Office of Rural Health, Michael Franklin – Atlantic General Hospital, Bill Jacobs-Intouch Health, Jennifer Witten-American Heart & Stroke Association, Marc Zubrow-Christiana Health Care Health System, Alexandra Podolny-U of Maryland Center for Health & Homeland Security
Attended via teleconference: Jo Wilson-Western Maryland Health System, Lori Brewster-Wicomico Health Dept, Sarah Orth-Maryland Health Care Commission

Welcome and Introductions

Dr. Bass welcomed everyone and introductions were made.

Overview of the Telemedicine Taskforce and the Advisory Groups

Dr. Bass gave an overview of the Telemedicine Taskforce, the three Advisory Groups and the tasks for the Telemedicine Clinical Advisory Group (TCAG) via power point presentation. (Addendum)

Dr. Bass stated that one of the issues the TCAG would be assessing is the possible need for legislation in 2012 and the role of the TCAG with regards to any legislation that is introduced.

Current and potential clinical uses of Telemedicine in Maryland

Dr. Aldrich stated that a lesson learned from the taskforce is it would be best to assess the Telemedicine needs in Maryland as opposed to what is currently available. Do not get bogged down in what is technically possible or not possible; let the technical advisory group know what is needed to enhance practice and patient safety. Dr. Stern added that the potential for telemedicine is to stretch across the continuum of care starting with pre-hospital care, through the emergency department to in-hospital care, rehab and home care. Priorities need to be defined, pick a couple of areas to start with; assess how the clinical needs mesh with technology and layer on experience to expand telemedicine in a true and deliberate manner. Although telemedicine denies geography; the reality is that Maryland is in a relatively small geographic area with several health systems that has limited bed availability across the continuum of care for multiple reasons. Take the perspective that what is best for the patient at a particular time and cross over traditional and historical barriers so that in the end all will benefit when approaching what is best for the patient in a particular setting.

- Dr. Stern also stated that with the direction of ACGME, there is an educational component to Telemedicine regarding clinical care by considering utilizing telemedicine to meet the evolving demands of resident supervision.
- Telemedicine could also be used for research in terms of remotely screening / consenting patients for clinical studies.

Dr. Zubrow stated that Delaware has been utilizing teleICU for over six years and that there is a distinction with telemedicine between point in time service and continuous service. As discussion moves forward point in time service such as stroke and ICU which is a continuous care, the cost difference is significant. Delaware will be implementing Neuro and Trauma Telemedicine in the next six months.

Dr. Bass would like to develop an inventory of services for telemedicine; classifying the different uses of telemedicine and reimbursements.

Dr. Aldrich stated that over twenty states have passed legislation regarding reimbursement in varying degrees.

Dr. Grady stated MHA has backed Mental Health for Tele psychiatry and that there is adequate reimbursement with Medicaid which includes a component for a social worker or practitioner under specific circumstances when medically necessary. COMAR Regulation change effective July 1, 2011.

Dr. Zubrow stated that CareFirst has shown interest in supporting telemedicine to reduce transfers and admissions and has already provided a three million dollar grant to the Maryland eCare program. One of the hospitals has recovered their own contribution through a 22% reduction in transfers.

Dr. Aldrich stated that the financial argument for the state of Maryland is not only who is going to pay for it (build it) but who is going to sustain it. Cost of telemedicine is coming down.

Dr. Reynolds stated that the recent Virginia Telemedicine legislation may be a good model for Maryland. California, who has been utilizing telemedicine for around the last fourteen years, is currently in the process of writing legislation to reduce any barriers and adopt more use of telemedicine to control costs.

- Telemedicine may allow earlier repatriation of patients
- Telemedicine may help keep local doctors to stay in smaller communities by allowing practitioners to use telemedicine from their homes.

Dr. Bass stated that the TCAG is not just about emergency care or the emergency care system. The TCAG will be looking at a broad use of telemedicine for a variety of clinical issues from primary care to emergency care to ICU to teleradiology.

Mr. Franklin suggested choosing a place to start; focusing on initiation and placement of telemedicine.

A discussion on cost effectiveness, additional initial costs, reduced costs on inter-facility transfers, fewer admission, fewer emergency department visits ensued.

Dr. Aldrich suggested having proposal for broad use of telemedicine but have four possible venues pre-hospital, emergency department, inpatient and outpatient. Start telemedicine in phases and build out with the three technical points: video consult, video consult / teleradiology, video consult / teleradiology / data.

Ms. Vaidya suggested starting with something that already has cost such as stroke to demonstrate how treatment can be more efficient with better outcomes.

Mr. Franklin noted that Blue Cross in putting funding in their five tiered demonstration project.

Dr. Colgan gave an overview of the NIH granted Telehealth project for chronic disease management between the University of Maryland and the Western Maryland Health System and ESAHEC.

It was noted that CRISP does not have a way to share images easily. Should telemedicine lead to HIE and how would this be sustained. The technical group is looking at standards e.g. images

Ms. Witten recommended considering the educational component and redefining what is Telemedicine / Telehealth. Depending on the specialty and what is needed, the TCAG can provide insight and guidance on the standards of clinical care. Develop what the standards in telemedicine would look like. Ms. Witten sits on the CRISP Board and stated there are current discussions on how to broaden the scope regarding imaging, although, it may be a slower time line; but, they are aware and considering within their model. Ms. Witten stated the group could provide parameters for the variables regarding cost analysis for telemedicine. Ms. Witten noted that third party payers were supportive of telemedicine during the last legislative session.

It was suggested adding CareFirst as an actuarial partner to the financial advisory group.

Dr. Zubrow will send the 100 page California report to Dr. Bass. The report notes that there was a great initial cost by California but is now reaping the cost benefit. It was noted that California started with outpatient telemedicine services.

Dr. Aldrich stated part of the plan should include moving forward with quality, safety, and cost data collection prospectively and built in the budget in order to determine and review the progress that has been made. Dr. Stern stated that as telemedicine evolves in phases over the next few years that we should prospectively collect data and what bullets need to be built into the system to capture the needed data to study the economics to know where savings have accrued and where we need to put additional funding. Have plan in place and a team for applying for grants.

Dr. Novello suggested the TCAG adopt the two tier framework for telemedicine that was discussed Tier (A) – pre-hospital through inpatient, Tier (B) – outpatient through home care. This would allow the group to divide along areas of expertise.

A discussion on the technical aspects of real time data exchange and repository ensued.

Dr. Handel asked how to establish a relationship with other facilities for specialty care. Dr. Bass stated that MIEMSS could potentially assist with a statewide on call system for specialty services utilizing the 24/7 Communications center and the HC Standard program which is the software MIEMSS has in every emergency department. MIEMSS is currently working on setting up a system for finding a psych bed when needed within the state using HC Standard.

Wrap up:

Timeline of submissions to the Taskforce:

- Advisory Group briefings due:
    - –August 29, 2011 – September 2. 2011
    - –October 11, 2011 – October 18, 2011
    - –November 14, 2011 - November 18, 2100 (final draft reports due)
    - –December 6, 2011 – December 9, 2011 (final reports)

Meeting notes and documents will be posted to the Telemedicine Taskforce web site at: http://www.dhmh.state.md.us/mhqcc/telemedicine.html

To keep the momentum the TCAG will meet every other Thursday at 2pm at MIEMSS and via web/teleconference. (Except for August 6, 2011which will take place at 10am)

The Maryland Telemedicine Taskforce white paper will be posted on the web site for review and suggestions for next meeting.

A schedule of dates and times will be sent via email.